

MINUTES
(Approved by the Task Force)

Health Care Task Force
November 17, 2011
Capitol Building, Boise Idaho
East Wing, Room 41

In attendance were Co-chairs Senator Dean Cameron and Representative Gary Collins; Senators Joe Stegner, Patti Anne Lodge, Tim Corder, Dan Schmidt and Joyce Broadsword (a newly appointed member of this task force, to replace Senator Stegner); Representatives Sharon Block, Janice McGeachin, John Rusche and Elaine Smith. Senator John Goedde, John McGee and Representatives Carlos Bilbao and Fred Wood were absent and excused. Legislative Services Office staff members present were Ryan Bush, Matt Ellsworth and Charmi Arregui.

Others present at the meeting included Representative Phylis King; Representative Sue Chew; Roger Christensen, Bonneville County Commissioner; Kathryn Mooney, Idaho Association of Counties; Steve Millard, Idaho Hospital Association; Rick Holloway, Idaho Health Care Association; Benjamin Davenport, Risch Pisca PLLC; Corey Surber, Saint Alphonsus; Woody Richards, Attorney/Lobbyist; Steve Rector, Pinnacle Business Group; Heidi Low, American Cancer Society/Cancer Action Network; Susie Pouliot, Idaho Medical Association; John Watts and Elizabeth Criner, Veritas Advisors LLP; Director Bill Deal, Elwood Kleaver and Tom Donovan, Department of Insurance; Marnie Packard, PacificSource; Cynthia York, Idaho Department of Health and Welfare; Shad Priest, Tim S. Olson and Lyn Darrington, Regence BlueShield of Idaho; Ray Stark, Boise Metro Chamber; Rochelle Kubinski, Business Psychology Associates; Joie McGarvin, America's Health Insurance Plans; Dennis Tanikuni, Idaho Farm Bureau; Jesus Blanco and Teri Barker, Idaho Primary Care Association; Corey Makizuru, Idaho Association of Developmental Disabilities Agencies; Julie Taylor, Blue Cross of Idaho; Peter Gray and Sandy Dunbar, Molina Healthcare; Dr. Steve Neeleman, HealthEquity; Toni Lawson, Idaho Hospital Association; Jared Tatro, Office of Performance Evaluations; Suzanne Budge, SBS Associates LLC; Jeff Weller, Idaho Commission on Aging; Penelope Schwiebert and Crystal Hutchison, Idaho Health Insurance Exchange (IHIE); Mike and Louise Berlin, Dr. Troy Rohn, Dr. Sarah Toevs and Teresa Molitor, Idaho Alzheimer's Planning Group (IAPG); Hannah Brass, Planned Parenthood; Louis Schlickman, M.D., Idaho Health Care for All (non-profit); Shawn Dunnagan, BSU; and Gretchen Eickmeyer, Pacific Northwest University of Health Sciences.

The meeting was called to order at 9:06 by **Co-chair Senator Cameron**; he welcomed everyone and called for a motion on the October 4, 2011 minutes. **Senator Schmidt moved that the October 4, 2011 minutes be approved, seconded by Representative Rusche and the motion passed unanimously by voice vote.**

The first presenter was **Matt Ellsworth**, Budget Analyst, Legislative Services Office, who gave an overview and history of the Catastrophic Health Care Cost Program (CAT Fund) which is available online at: www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_ellsworth.pdf **Mr. Ellsworth** explained the program's purpose was to meet the needs of medically indigent in Idaho who do not qualify for state or federal health and welfare programs, but do qualify for county assistance. Medically indigent people are those in need of medical services but don't have resources to pay for those services, and this has been the case going back twenty years in statute. He referred to 31-3503: "The

board of county commissioners in their respective counties shall... Care for and maintain the medically or otherwise indigent..." This allows counties to levy property taxes to pay for indigent medical expenses, which became a burden for many counties.

In 1982, Senate Bill 1311 created the CAT Program and defined "catastrophic health care costs" as those in excess of \$10,000; counties paid into the account; the resident county paid up to the "catastrophic" level, then the CAT Program picked up the rest. From 1982-1990, various statutory modifications were made, including reimbursement from indigent individuals able to pay, and also tied payment rates to Medicare and Medicaid reimbursement rates. In 1991, there was a CAT Program overhaul which removed contribution of county funds; established the Catastrophic Health Care Cost Program Board; required that the state shall "fund the catastrophic health care program..." and left indigency determination to counties. In 1995, a state/county partnership made counties responsible for the first \$10,000 of eligible claims and "...remainder of the eligible costs of the claim shall be paid by the state catastrophic health care program." In 1996-2008, various statutory modifications were made, including timelines, investigation requirements, property liens, notification, etc. In 2009, Senate Bill 1158 called for major program modifications redefined "catastrophic health care costs"; increased county deductible amount from \$10,000 to \$11,000; required program administrator to work with DHW on Medicaid eligibility review, utilization management; and revised makeup of CAT board to 12 members. In 2010-2011 program administration clarified timelines; tied reimbursement rates to unadjusted Medicaid rates (95%, until 7-1-2013); required applications from providers/hospitals; clarified how claims move through the process. There was a contract administrator until 2010, at which time the CAT Board began contracting with IAC for program administration. **Mr. Ellsworth** explained the claims process and gave a program cost summary showing state payments from 2000 to 2010 grew from \$5,885,700 to \$33,771,700, a 473.8% increase.

Co-chair Cameron clarified that in 2009 there were significant changes in utilization management which is supposed to save millions of dollars; this task force tries to watch to see if this actually has taken place by working with DHW to issue that contract and to monitor how that has been working. He pointed out that may be an area to watch more closely, both claims management and utilization management of the CAT Fund.

Representative Rusche thought it would be helpful to point out the definition of "indigency" because this really isn't a health plan, it's a reimbursement mechanism. Although numbers have increased in cost and number of cases, he was interested in dollars per case both that are ceded to the reinsurance mechanism of the CAT Fund and the dollars per case the counties see as well. **Mr. Ellsworth** agreed to get that information to the task force after this meeting. The CAT Board watches closely the dollars per case, and said that the next presenter might cover this.

Senator Corder spoke about the balance of the CAT Fund in 2010, and asked if any efforts were undertaken as to why there were carry-over amounts in some years (2003-2006 and 2009) but not in 2007 and 2008. **Mr. Ellsworth** said he assumed that the level of claims submitted for reimbursement did not end up exceeding the amount of money appropriated and was carried over from a preceding year.

Senator Schmidt stated that since the CAT Program was a reimbursement program for the uninsured who incur catastrophic costs, he asked how large that pool is in the state of Idaho. **Mr. Ellsworth** responded that this was being watched, adding that health care reform could significantly impact this

program and how it functions in the future. **Co-chair Cameron** added that it was different with each county; some counties are heavy utilizers of the CAT Program and others are not, for various reasons.

The next presenter was **Roger Christensen**, Bonneville County Commissioner and Chairman, CAT Fund Board, who gave an update on the CAT Fund and his PowerPoint presentation is available on our website at: www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_christensen.pdf

Mr. Christensen answered several questions previously raised today; he said a brief definition of “indigency” was someone not having the ability or resources to pay a medical bill at the billed rate within five years. He said there was an extensive formula counties go through to determine resources, income and allowable expenses and a person’s ability to pay off a medical bill. There is not a certain income threshold, but is based on the amount of a claim. Individuals in the indigent program have no other resource other than the CAT Fund and they must qualify according to statute. He said that the 2010 year-end balance of the CAT Fund (\$5,583,600) was during the transition time when administrators were changed and not all claims from 2010 had been processed, but were carried over into 2011 for payment. **Mr. Christensen** said that the number of cases paid by the CAT Fund had risen from 1101 in 2008 to 1333 cases in 2011 and projected to be 1500 for 2012 at an average amount per case of \$24,603 currently. The CAT Fund Board is working on a more accurate reporting system to track numbers better. One concern for 2012 is the sharp rise in the number of cases per month with the current economy. He predicted that 2013 will be about the same as 2012, due to changes in legislation. **Mr. Christensen** predicted that the 2012 supplemental request would be around \$20,992,418. For the last three years, a projections history was shown versus actual incurred claims paid out, and the differences ranged between 2.6% and 3.2%.

Indigent trends were shown, annual county cases numbering 4,323 in 2009 to 4,590 in 2011, and about one-third of these are passed on to the CAT Program. Total costs have gone up annually from \$44,516,529 in 2009 to \$51,115,564 in 2011. Since July 31, 2011, 172 county cases have been reviewed since the CAT Board undertook a contract with an independent reviewer in cooperation with counties for claims review. So far, 23 of those 172 cases have come to the CAT Board, resulting in about \$451,097 in savings. The Board anticipates more current up-to-date numbers as they get closer to the January reporting date, but it appears the savings is about \$20,000 per case. Another change made in legislation was having applications go through the combined applications unit with DHW to see if screening could result in qualifying some applicants for Medicaid, prior to coming to the county. Statistics were given on Medicaid determinations for a three-month period ending September 20, 2011. Due to a change in statute, counties are not having to pay claims and then go back for reimbursement, so future reimbursement numbers should go down. Alternative coverage is being looked at by counties to assist individuals deemed indigent and to also reduce costs. **Mr. Christensen** gave examples of types of medical incidents, costs, what the Medicaid rate would have been to counties and the amount of savings to the state using COBRA and also a pre-existing condition insurance plan (PCIP). He said PCIP was a win-win program for both the state and hospitals because the hospitals are reimbursed at a higher rate under the insurance plan than under Medicaid. Some hospitals participate in paying those premiums for coverage for only those deemed indigent under statute. He said there were approximately \$14 million in costs in the category of chronic, ongoing claims and he thinks that a significant percentage of those claims could be picked up and result in a savings to temper increasing costs at the state level. He said that medical reviews will be done by an independent medical review to make sure the condition warrants a procedure.

Mr. Christensen said the CAT Board is seeing trends causing concern which have a quicker effect on issues regarding mental health, and the number of protective hearings have more than doubled over the last year. These cases will eventually impact county and state budgets in many ways. When people lose resources and incur medical bills and higher health care costs, increased costs result in the CAT Fund. Federal health care reform could impact the CAT Fund positively if more people are insured. Some counties are working on preventative care to try to contain costs. The service contract with IAC has been extended for two years, realizing that federal health care is unsure. Many processes have been streamlined, and more accurate numbers are available to reflect what is going on in the CAT Fund. There is cooperation between counties and the CAT Board in trying to solve problems, even though there are still issues in some counties being worked on. In 2009, legislation added members to the CAT Board, and **Mr. Christensen** added that adding two legislators to this board had been a very positive change, providing better communication and understanding at the state level. To contain indigent costs, eligibility criteria can be adjusted, income levels raised, restricting types of cases paid for, and adjusting reimbursement rates being paid for services. Getting individuals involved who are covered through alternative programs may be the most fruitful and the most promising programs currently, and the CAT Board will continue to work on this through legislative representatives.

Senator Corder said he was curious about steps being taken to analyze trends with regard to mental health. With regard to the many changes made in the past affecting current psycho-social rehabilitation (PSR) services, is information available to form a meaningful, prudent conclusion? **Mr. Christensen** answered that would be difficult and beyond the current ability of the CAT Board. He added that there has been quite an increase and through IAC, counties are being encouraged to track types of cases coming in to gather better data, and DHW could help with that.

Senator Schmidt inquired about COBRA coverage specifics and how that would be done at the county level. Is there other coverage available to keep a person from not falling into the indigent category? What if that person could not afford COBRA coverage, even though that would provide significant savings? He wondered how that was addressed at the county or state level. **Mr. Christensen** replied that goes into the same grouping as PCIP which is another type of insurance. An example is if a person lost a job but were still eligible to pick up COBRA benefits, if a bill was incurred and came to the county, they would be indigent since no resources to pay the bill. A COBRA incident would not happen as often as the PCIP program, but the CAT Board is seeking legislation to examine this, since it would benefit everyone to pay the cost of that premium and get that incident paid through a program, rather than paying through the state general fund.

Representative Rusche offered additional background on chronic conditions stating that many patients who reach the reinsurance threshold, not those seen by the county, are cancer patients who usually present after initial diagnosis, treatment and/or surgery and can incur bills of hundreds of thousands of dollars. Cardiovascular disease patients have an ongoing need for services. Many mental health patients who do not meet social security disability criteria have episodic illnesses, since this is the nature of the disease, or are on treatment. These three categories have real opportunity to seek an insurance policy, but the program is not well designed for that kind of payment. Medical services are usually up front and reimbursement is after the fact; if these bills total up to more than can be paid back in five years, then eligibility for support results. In situations where there is a very high likelihood to incur huge expenses going forward, alternatives must be explored to pay for these cases. He asked **Mr. Christensen** to discuss health reform, since by 2014 with the expansion of Medicaid and tax credits available to purchase individual and small group insurance, he believes that the CAT Fund will have to change

considerably. **Mr. Christensen** answered that this is part of the uncertainty since there is a Supreme Court challenge and an election pending, so everything is in a state of flux. The CAT Fund is being managed with current rules with an uncertain future looming. If health care reform legislation takes effect and more people are covered, that could reduce the CAT Fund to almost zero.

Co-chair Cameron referred to the slide on the CAT Fund presentation showing savings for claims reviewed, asking for more detail, since he was interested in what the county side of that savings is, and not just the CAT Fund side. This issue was at the heart of draft legislation having been worked on in 2009. He said that one other piece that doesn't seem to be off the ground is utilization management, agreeing that the CAT Fund is more of a reimbursement plan than a health care plan. A statewide contract to help all counties and the state has been discussed, to better manage care, particularly with ongoing, chronic conditions, before huge costs are incurred. He asked for an update on where the state is with regard to this, since it seems to him that this is moving too slowly. **Mr. Christensen** replied that he could not respond as to what is going on within DHW, and that is why the CAT Board has undertaken with the counties to do the medical reviews in the interim, recognizing that something had to happen. This is not as extensive as what was anticipated under the utilization management, but it's the best effort with current resources. He said that the medical review savings of \$451,000 is all state, recognizing on those 23 cases that the county is still obligated for the first \$11,000. He added that in Bonneville county, \$80,000 had been saved in deductibles by having pre-ten-day priors coming in for preauthorization reviewed and getting another opinion, saying that wasn't eligible. That is how counties can save, but the bulk of savings comes from the CAT Board at the state level. One policy of the CAT Board is requiring counties to have reviews done on any claim over \$75,000; this is a voluntary cooperation and does take time. Seeing results of that, the board may decide to require this same review at a lower threshold amount, but they don't want to overburden the current system. Another challenge is convincing some counties that this is a partnership between counties and the state, and that counties should worry about more than just the first \$11,000.

Co-chair Cameron suggested that perhaps there should be a review on every claim over \$11,000. **Mr. Christensen** said the board is watching this and trying not to overwhelm the reviewers. The cost of each review is \$200-\$400. **Co-chair Cameron** asked about the 172 cases that were reviewed and **Mr. Christensen** answered that 172 cases are in the pipeline being reviewed, as reported by the board's contractor, and 23 of those cases have hit the CAT Fund, meaning that maybe the review has been done at the county level and hasn't been approved to be sent in yet. **Co-chair Cameron** asked if out of the 172, only 23 of the cases exceeded the \$11,000 and **Mr. Christensen** answered "no" that it was just a quick grab of some numbers. He said that some of those will never hit the CAT Board, for example the 8 or 9 from his county were ten-day priors and those never happened; some of those would have been CAT cases. He said it's hard to tell what the savings to the state would be, but because this is not being paid for, the county is saving \$11,000. **Co-chair Cameron** said on the 172 cases reviewed, 23 had a savings amounting to \$451,097; he asked if there was no savings in the medical review of the other 149 cases. **Mr. Christensen** clarified that in the other 149 cases, some of those will still be coming to the CAT Board; a more up-to-date report will be available in January and better numbers. This information was simply to show that reviews are fruitful. **Co-chair Cameron** agreed and he asked for those specific reports on savings to counties from medical reviews, since some cases will never reach the CAT Fund. He would also like to see an ongoing report of savings from year-to-year; he thinks claims review is great, although after-the-fact. **Co-chair Cameron** hopes that there can be better management on the front end of health care so that patients can be served much less expensively. He asked about substance abuse costs which are significant in the CAT Fund; **Mr. Christensen** said that many mental health

issues involve self-medicating, causing at times substance abuse; he said the CAT Board was not involved in any programs involving substance abuse. Once patients get help after entering the judicial system, there are promising programs such as the JoAn Wood Pilot Project by treating both disorders. The specialty courts, drug courts and mental health courts have had success, but the CAT Board is not currently involved in other programs. **Co-chair Cameron** said this is another place where utilization management could possibly help.

Co-chair Collins asked about the service contract with IAC that was extended a few years, asking what that actually does and the cost. **Mr. Christensen** replied that in the past, there was a contract administrator; when a change was made, this went to a service provider and put the report in the role of the administrator. It's primarily a claim processing review, including education, and duties are much greater than with the prior contract as far as requirements for reporting, training, etc. The contract that was just signed costs about \$1,500 monthly, less than was paid for the prior contract three years ago, and the caseload alone has risen about 30%. The contract includes work on PCIP, medical reviews and trying to implement new programs with a good relationship between state and counties on this program.

Representative Rusche asked about utilization management, saying that it was virtually impossible to change utilization once it has already occurred; this program is not structured other than the preauthorization or ten-day priors. The other problem is that there are services excluded from coverage such as nursing home care; however, if nursing home care is a lesser cost alternative to inpatient hospital care, a lower cost care should be an option, in his opinion. This program has provided a great deal more information than with the prior administrator. Great strides have been made, but because of the structure of this reimbursement program, it's going to be very difficult to do proactive management care.

Senator Lodge thanked **Mr. Christensen** for all his work on the CAT Board, having seen huge improvements in accountability. She asked about any work being done county-to-county with the local medical associations and other providers and ways they can cut costs for the CAT Fund. **Mr. Christensen** said that the PCIP is a good example of that and IAC is attempting to set up training meetings to try to educate applicants on filling out applications to avoid contention. The best opportunity for a cooperative program is something like PCIP since hospitals can enroll, rather than the county. The patient can be deemed indigent, and the hospital will receive the reimbursement rate of 50%, which is the Medicaid rate, but if enrolled in this program, the hospital receives approximately 80%. **Senator Lodge** asked if that would include any providers like the doctors, since many of those doctors work for hospitals. **Mr. Christensen** thought it would cover the bill, but said he was not sure of all the rules, since it was basically an insurance program.

Senator Corder wondered about health insurance exchanges; regardless of the outcome of the affordable health care act components in the courts, there are pieces that will be implemented and irreversible, having an impact on everything going forward. One impact could be some sort of an offset with the state system; will the exchanges, if established, represent any sort of offset to the CAT Fund? **Mr. Christensen** said that he did not know, since the landscape is changing so rapidly, but that is why it is important in the arrangement the CAT Board has with IAC to be flexible in order to monitor and adjust quickly. Demand should, in theory, be reduced since more people will be insured.

Senator Corder said it would seem to be an advantage of the state to be in charge of the components of a health care exchange, tailoring it to serve as an offset. **Mr. Christensen** affirmed that to be true,

adding that the Legislature would make the decisions and the CAT Board would do their best to administer the program.

Co-chair Cameron thanked everyone on the CAT Board for the work they do; he said that work done in 2009 had been fruitful and he stressed the importance of good communication between the Legislature and the CAT Board.

Dr. Stephen Neeleman, M.D., Chief Executive Officer, HealthEquity, presented next and his PowerPoint presentation is online at:

www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_neeleman.pdf

Dr. Neeleman has published a book entitled “The Complete HSA Guidebook - How to Make Health Savings Accounts Work for You” which is available online www.hsaguidebook.com. Enter the promotional code: HSASmart2011. **Dr. Neeleman** is a trauma surgeon from Utah, and he explained he has a passion for providing hope about how to pay for health care for the next hundred years in our country. He said that HealthEquity serves about 18,000 employers, over 450,000 health accounts and over 30,000 reimbursement accounts. HealthEquity is the custodian of over \$650 million dollars in health savings account (HSA) deposits which people will take with them into retirement. This is their money, not an employer’s money, and is in accounts regulated by FDIC and U.S. Treasury, completely portable funds owned by the employee. HealthEquity is the custodian, governed by the IRS and regulated by their entities.

Dr. Neeleman explained the benefits of HSAs, which is not at all the same as an FSA (flexible spending account). A person in an HSA still has a dominant health plan which allows major medical protection, discounts, and care management to hold down costs, and HSAs are offered by almost every health insurance carrier in the country. An HSA is a triple-tax advantaged savings account used for medical expenses and savings for retirement; a person puts money into an HSA, and there are no taxes on that. If an employer makes a contribution, it can be written off as a business expense and there is no FICA tax. While these dollars in the account grow, like a 401K, no taxes are owed on that growth. The remarkable thing is when you spend HSA money on health care, you pay no taxes. He believes that the answer to the Medicare dilemma and the donut hole is a bonafide HSA. Consumers with HSAs can research lower cost alternatives and become empowered consumers of health care, and there is no use-it-or-lose-it provision with HSAs. To be eligible to make contributions to an HSA, you must be covered under a qualified high deductible health plan (\$1200 single, \$2400 family). **Dr. Neeleman** went over fears and facts about HSAs. FSAs excel spending, and HSAs have the opposite effect. HSAs can be invested, used for retirement like other retirement accounts, and passed on to heirs. He believes that FSAs are remarkable opportunities that too few Americans know about. Money saved can be rolled over each year and invested, allowing the HSA to grow. HSAs will be largely unaffected by health care reform. Critically important, **Dr. Neeleman** said, is the fact that if you’re in a non-HSA or non-account based plan, an average employee in this country will spend \$10,400 annually in health care. If you are in a plan having less than 10% in HSAs, costs go down 4%; if you are in a plan with significant adoption where more than 10% are in HSAs, costs go down to \$8,900, over a 15% discount. If you took 15% off the top of employee’s health benefits at the same time employees can save their own money and avoid taxes, that would be nirvana. Employees love HSAs for tax avoidance and long-term savings; employers love HSAs because remarkably, people definitely behave differently when they are spending their own money.

Dr. Neeleman said that the University of Idaho has been offering HSAs to their employees and have 90% agency adoption over three years, resulting in lower medical cost trends and 22% of employees have

over \$5,000 in their HSA. Idaho Power has 30% adoption and average account balance for the whole population is more than \$4,000 after a few years, and 25% of employees are investing their HSA dollars in mutual funds. American Express has 100% adoption with 25,000 employees and each one is accumulating HSA dollars for retirement savings; the three-year cost savings is estimated to be \$100 million, and this population is roughly the size of the state of Idaho employee population. Think about \$100 million and what Idaho could do with that money.

Dr. Neeleman talked about integration, making it easy for the member and how HSA accounts are easily managed online. A patient can even go online to find suitable alternative drugs which could save as much as \$1,280 on one prescription. Patients and doctors alike are very good at spending other people's money, but HSAs encourage consumer involvement and huge savings can result.

Representative McGeachin asked about the Department of Labor logo on a few pages in the PowerPoint presentation and **Dr. Neeleman** explained that he just used that sample logo as an example to show how a person in Idaho could refer to an account online. **Representative McGeachin** asked about the example of the woman saving \$1,280 on a medication; she asked if HealthEquity provides that website and information to enrollees and **Dr. Neeleman** answered "yes." HealthEquity is HIPAA compliant and available to members 24/7 as well. As a doctor, he knows that emergency rooms are double staffed after 5:00 p.m. and single staffed during the day because people get sick at night. He added that there are companies who choose to only have a bank administer their HSAs, and most banks do not want to be HIPAA compliant. So, it depends on who the HSA partner is, whether or not such information would be provided showing lower cost alternatives.

Senator Cameron asked **Dr. Neeleman** if he was working with the University of Idaho and others, and **Dr. Neeleman** affirmed that he was.

Senator Stegner asked about the \$650 million deposited in HealthEquity HSAs, and he asked if this was managed personally by **Dr. Neeleman** and the response was "No, I am a doctor." He explained that HealthEquity went through a very onerous process to be licensed as a non-bank trustee through the U.S. Treasury Department, so they are audited by the IRS as a custodian on an annual basis. HSA accounts are complicated, but HealthEquity has an IRS custodian who manages that money; operationally, every day as contributions come in from employers and individuals, that money is swept into bank accounts that are FDIC insured. **Senator Stegner** asked about volatility in account balances and **Dr. Neeleman** explained that only 10% of the money is exposed to a volatile market, but it is an individual's choice how contributions are invested. With 90% being invested in a secure savings account, it goes up annually. **Senator Stegner** asked whether new clients signing up were advised of risks, choices and investments. **Dr. Neeleman** said that the safe landing for standard employees is that their contributions can go into a savings account, interest is paid and it is insured. Once there is over \$2,000 in an account, the website then asks if that person would like to invest and disclosure is presented and information given about any volatility versus being protected. **Dr. Neeleman** said that the administrative fee is very small and there is no incentive for HealthEquity to encourage members to contribute to volatile accounts.

Representative Rusche asked about the HealthEquity website and how this integrates with the back-end, high deductible, the health plan that sponsors that product. **Dr. Neeleman** explained that the health plan is the driving force (like a motorcycle) which has the discounts, the plan designs, and the HSA is like a sidecar, using information they make available to the market and then put in into their HealthEquity website in an environment where people see and use it easily. Normally, people do not normally visit a

website for their health plan more than once yearly; HealthEquity members visit their HSA website monthly.

Senator Schmidt inquired about enrollment and variables described, referring to 90% of eligible employees at the University of Idaho having HSAs. **Dr. Neeleman** explained that almost all employees at the University of Idaho are in HSAs. **Senator Schmidt** asked for an explanation on how different companies go about allowing or encouraging participation in HSAs. **Dr. Neeleman** said that employers have to choose to offer HSAs and that currently the state of Idaho does not offer the option of HSAs to state employees; to sign up, employees would have to go outside the benefit and would then lose the subsidy of their employer. There is a fantastic book **Dr. Neeleman** referred to called “Nudge” and it talks about everything from organ donation programs to school lunch offerings and choice architecture. It basically says that if a successful program is run, there are choices; one choice could be to opt in (about 20% participation results) or to opt out (resulting in much better participation) due to inertia. Sweden does not give the choice to donate organs; if you live in Sweden, you donate. American Express chose to be like Sweden; if you want health benefits from them, knowing what is likely going to happen to Medicare, they want employees to have money put aside and to avoid taxes, so to work for American Express and have health benefits, then employees must have an HSA. Other companies and states make it fair, so that members are not financially penalized for doing so. There must be a level playing field, but there are many choices and scenarios included in the book “Nudge” which is very informative. The full name of this book is: “Nudge: Improving Decisions About Health, Wealth and Happiness” written by Richard H. Thaler and Cass R. Sunstein.

Representative McGeachin said she was struggling to understand the difference between why PPACA (Patient Protection Affordable Care Act) seems to be picking on FSAs over HSAs. **Dr. Neeleman** answered that he didn’t know for sure, but he did say that he knows FSAs accelerate spending. Every person with extra FSA money is trying to spend it before the cutoff date, and there are even commercials promoting FSA spending.

Co-chair Cameron reminded the task force that at the October 4, 2011 meeting, DHW discussed Molina claims processing system at length, and he thought that providers should be given an opportunity to share their experience in using that Molina system in processing Medicaid claims. Therefore, a panel of these four providers spoke next: **Susie Pouliot**, CEO, Idaho Medical Association (IMA); **Steve Millard**, President, Idaho Hospital Association (IHA); **Rick Holloway**, Idaho Health Care Association; and **Corey Makizuru**, Idaho Association of Developmental Disabilities Agencies.

Ms. Pouliot’s PowerPoint presentation is available online at:

www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_pouliot.pdf

Ms. Pouliot addressed how the Molina system has affected physicians in Idaho. When Molina was first launched in July, 2010, the IMA began to track problems reported and took on the role of an intermediary between Molina, Medicaid and IMA members to help organize the volume of issues being reported. Since July, 2010 the IMA has documented 130 issues related to Medicaid, and nearly all were Molina concerns, and now most are resolved. Several issues are open on the IMA end, for tracking purposes only, but claims issues have in one way or another affected all physicians in Idaho and several out-of-state as well. From the perspective of IMA, the claims processing system by Molina has greatly improved and problems have been identified and addressed. Molina has willingly worked with the IMA as a partner to improve the system for physicians and patients, and **Ms. Pouliot** expressed gratitude for that. She said there have been occasions when an issue has been resolved, and, as a result of that fix,

another problem or two pops up. She shared an overview of issues that continue to be tracked, and the biggest issue was at first enrollment and problems with initial setup in the Molina system, which affected payments. Significant progress has been made in this area, but problems persist; however, Molina representatives work closely with offices affected to help them through problems on a one-on-one basis. Molina has addressed significant customer service issues and has shown improvement as a result; however, once in awhile miscommunication issues are reported. Customer service certification has improved the system. Claims issues were the biggest driver of problems physicians saw in being able to be paid appropriately; many major claims issues have been resolved, but some remain. Medicaid made interim payments to providers who were not being paid through the Molina system, and there are ongoing efforts to recoup those payments and overpayments. Action Collection Service sent letters to providers regarding failure to repay interim payment debt only after repeated attempts by Medicaid and Molina to collect payments.

Ms. Pouliot expressed concern about the 5010 transition since compliance impacts all providers. IMA's concern is that given the problems experienced with Molina in processing claims initially, any major change to the system could cause disruption, so the IMA is cautiously looking at this. Testing of Version 5010 now will allow adequate time to fine-tune systems since it must be implemented on January 1, 2012. Molina anticipates readiness for testing in mid-December.

Coordination of Benefits (COB) was discussed, which is a provision used to establish the order in which health insurance plans pay claims when more than one plan exists. Initially, Medicaid was paying claims as the primary payer for quite awhile; now Molina is reprocessing those claims. The hospital claims are now being reprocessed first, those being the highest dollar amounts that were paid incorrectly. Physicians and other providers will have claims reprocessed next. Molina provided outreach to those affected and will continue to make those efforts. A system fix should also solve the problem of incorrect payment when Medicaid was the third payer of claims, an issue still problematic, but easily corrected by Molina. **Ms. Pouliot** said the IMA recently became aware of inappropriate recoupment of payments for well-child visits from certain patient types. Those claims have been identified and IMA awaits confirmation that corrections are being made. Another issue with Healthy Connections was availability of the roster which lists Medicaid patients for whom physicians are paid a monthly capitation fee. When physicians received payment for patients, the offices were unable to reconcile those payments; that issue was recently resolved. A patient co-pay amount of \$3.65 for each appointment was adjusted annually beginning November 1, 2011, for podiatrists, chiropractic care and optometrists. Beginning January 1, 2012, this same co-pay will apply to physical, occupational and speech therapy, and all doctor's office visits, unless the visit is for preventive care or family planning. IMA is watching very carefully to see how the Molina system can adapt to new changes and be able to process claims for which co-pays apply. The Molina system must be accessed by a physician's office on the day of service to determine patient eligibility for Medicaid and also if the service has a co-pay or not. There are exemptions to co-pays, and complexity results, so IMA will monitor this carefully.

Overall, **Ms. Pouliot** said that the vast majority of problems with Molina have been resolved, even though some exist, but Molina is making a very concentrated effort to approach those systematically and Molina has been very open to working with IMA in addressing issues.

Mr. Steve Millard, President, Idaho Hospital Association (IHA), presented next and he said that hospitals experienced "a perfect storm" since in May, 2010 Medicaid held hospital payments for two months. The Molina system was to start paying claims on July 1, 2010, so all those claims held hit the

system at the same time, plus new claims which created absolute chaos for hospitals. IHA's first involvement was around July 21, 2010, and that meeting led to weekly conferencing meetings with Molina, and every hospital in IHA's membership was invited to participate. In the beginning, IHA had about 150 issues with the Molina system, very similar to IMA's list of issues, and it was frustrating. It was a learning process on both sides between hospitals and Molina; after about six months when issues were beginning to be resolved by Molina, then bi-weekly meetings started in February, 2011. On June 22, 2011 a meeting took place on coordination of benefits which was a big issue, and in late July, 2011, monthly meetings have taken place with Molina. All through this process, Molina was extremely interested in resolving issues and more resources resulted in much better service, which was a huge job. Things have gotten much better and issues resolved in much less time than when new systems began in other states. When **Peter Gray** came on board with Molina to resolve problems, IHA found things got done better and more quickly and **Mr. Gray** had a very standardized way of approaching issues, addressing issues immediately and giving a time frame for resolutions he didn't have answers to on the spot. **Mr. Millard** said that IHA now has about nine issues left including COB reprocessing, but progress is made weekly. **Mr. Millard** said that Molina has done everything they possibly could to help hospitals get through this truly "perfect storm" early on and was very impressed with Molina's ability to resolve issues and said he has faith that future issues will be resolved quickly. Molina partners with IHA to resolve issues; this is very important to IHA members and is working very well.

Mr. Rick Holloway, President, Western Health Care Corporation, is also owner/administrator of Owyhee Health and Rehabilitation Center in Homedale, a skilled nursing facility. He manages a combination nursing/skilled nursing facility in Salmon and provides consulting services for several rural hospitals, nursing homes, and assisted living facilities all over Idaho and Nevada. **Mr. Holloway** presented next and his presentation is on LSO's website at:

www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_holloway.pdf

Mr. Holloway stated that providers were never included in the design phase when Molina was preparing to take over the Medicaid billing process in July 2010. Had they been involved, he believes that problems would have been significantly diminished.

Mr. Holloway said that three major issues important to providers are in various stages of completion at present. The first has to do with rates paid per patient day; there were problems getting the correct payment rate in place and updated when finalized rates were established. This reprocessing is not yet complete, but since October 2010 the claims process has been corrected. The second issue has to do with patient share of cost. There have been considerable problems getting the share of cost deducted from the amount paid from the state from the start of the Molina billing system rollout. Just in one facility in Salmon, **Mr. Holloway** estimated there is at least \$40,000 in share of cost payments that should have been deducted from checks but weren't, and there is no way on the Molina billing system to send adjustments in electronically to get those claims reprocessed. Information was sent to Molina, but claims have yet to be reprocessed. Imagine the difficulty in collecting share of cost from patients who may not have been in a facility for over a year. What ends up happening is that the facility ends up losing that money and writing it off; in his building, that amounted to \$15,000 per year, causing severe financial hardship.

The third issue had to do with COB when a Medicaid patient goes to a hospital and comes back covered under Medicare Part A. Two years ago, Medicaid stopped paying the Medicare co-payment and that co-payment is covered by Medicare as a bad debt expense. Very specific information is needed from Medicaid and Molina to show that amount is not payable by Medicaid, and the nursing facilities can then

claim that expense to be paid by Medicare. This issue has now been resolved, thanks to regular meetings with Molina.

One area not resolved is the need to re-enter all patient information, diagnosis codes and other billing data every single time a claim is entered into the online portal. This greatly increases the chance for errors made in claims submission. This problem adds countless hours each month to the billing process across Idaho. **Mr. Holloway** pointed out that Molina meets with providers monthly to resolve issues, admitting that many early problems were not all the fault of Molina. He said that Molina is now working their hearts out, but Molina started out in a big hole by not having all information necessary at the start and how everything was supposed to work. He is still very concerned about the assisted living claims not being reprocessed. He believes there may be millions of dollars sitting on the books of assisted living providers that should be returned to the state. Decisions that legislators will be making in the upcoming session will be based on claims data from DHW through Molina, and the dollar amounts presented to legislators, he believes will not be correct. He thinks the amounts will likely be overstated because the patient liability amounts were not deducted as they should have been. He believes this should be considered when setting the DHW budget for the current state fiscal year. **Mr. Holloway** thanked the task force for this opportunity to speak and to Molina for their willingness to continue working through and resolving issues. He reiterated that **Peter Gray** and others had been phenomenal, working diligently to resolve issues.

Mr. Corey Makizuru, Administrator of a private Developmental Disabilities Agency, is also the Secretary/Treasurer for the Idaho Association of Developmental Disabilities Agencies (IADDA) and he spoke next. His presentation is available on LSO's website at:

www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_makizuru.pdf

Mr. Makizuru said that Medicaid Management Information System (MMIS) has been working well processing claims and paying providers for rendered services. The majority of agencies report that they have been receiving payments in the 98% to 99% range of submitted claims. Molina has made vast improvements to their system. Nevertheless, Molina needs to continue its efforts to remedy and enhance their system. The system and processes need to be more efficient by minimizing unnecessary and erroneous actions. In addition, there are too many steps which are very time consuming and cumbersome. There needs to be more accessibility to obtain accurate fiscal information. Molina needs to be better prepared for future and ongoing system changes. Provider enrollment problems need to be minimized by correctly identifying and designating specialty codes per provider type. The MMIS portal problems need to be minimized; the system disconnects while providers are online. There are problems with correctly identifying and designating which service code requires prior authorization numbers. In summary, three issues on which to focus are: (1) more efficiency; (2) accessibility of fiscal information; and (3) problems with the new Children's System Redesign (IDAPA 16.03.10. 660-666 & 680-686).

In closing, **Mr. Makizuru** acknowledged that we live in a great state which acknowledges and acts upon its compassion and responsibility to promote and protect the health and safety of all Idahoans. As a community, we made it a priority to help families in crisis situations as well as promote and protect vulnerable children and adults. He thanked everyone for their diligence and service.

Representative Rusche expressed concern about the fact that when a "fix" occurs in Molina, often it causes another problem elsewhere. This says to him that Molina doesn't yet have an adequate quality assurance process and, as upcoming system changes approach, mechanisms need to be in place to report quality performance and made available to those on the outside. He asked if Molina could accurately

make changes as required by ICD-10 (Compliance 2013) or statutory changes, and if the providers think Molina can do that. **Ms. Pouliot** answered that Molina has been very willing to work with IMA weekly as soon as issues are identified and reported; however, she said she could not give an appropriate answer as to whether Molina could do quality assurance up front. **Mr. Millard** said that initially the IHA experienced the same problem of fixing one thing and that fix causing a different problem elsewhere, which seems to be in the past. He believes that Molina currently has internal bugs worked out. **Mr. Holloway** answered that if that question had been asked a year ago, he would have a different response, but now with the ongoing communication with Molina, he thinks Molina is committed to making the system work. **Mr. Makizuru** said he concurred that Molina was motivated to make the system work; the concern he has is with timing issues. This new system, approved by the Legislature in March 2010, was to be implemented July 1, 2010, scheduled to go live on October 1, 2010, yet still has issues. Providers who deliver services need to be paid, and the challenge with agencies is dependent upon how they are structured as to whether they can remain solvent. The cause may be due to simply not completing the many steps required. The process is evolving, and Molina learns along with providers as to what has to be done. He said he is confident that Molina will fix the system or have it ready, but the question is how long that might take.

Senator Broadsword expressed concern about the enrollment applications being so cumbersome, asking if the DHW offered any triage to help agencies figure out how to respond to these requirements. **Mr. Makizuru** answered that the application his agency completed was done a day prior and upon review of the 94 page packet, much information DHW already has, that Molina already has, and there was a concern originally about enrollment specifically with properly identifying specialty types. Even though many agencies were diligent getting proper application forms done accurately, in many cases staff went to the actual training with Molina and still it became a large issue why many providers were not being paid, since information was not in the system correctly. The challenge remains when an agency provides different types of services or specialty types or multiple Medicaid ID numbers, much needs to be entered into the system and any errors disrupt payment. Looking at the packet of information, the protocol is for the agency to actually FAX this to Molina, then it goes to DHW, and when DHW approves the process, then it goes back to Molina before being entered into the Molina system. This process may improve in time, but he thinks that it is cumbersome. Part of the 94 page packet includes every member of his direct care staff who will be administering services, and there must be proof that they meet qualifications. Diplomas, licenses, certifications, and training materials need to be provided to Molina, and it remains to be seen what happens from there.

Senator Schmidt asked **Mr. Makizuru** if he had been in touch with DHW about the possibility of interim payments during the delay in enrollment. **Mr. Makizuru** said they had not been in touch with DHW and that they didn't anticipate the need for interim payments, since agencies are not predominantly relying on that revenue source to cover operational expenses. With statute changes and new services being provided, there is a year transition process. Not every child in the state is receiving services under the new system; it was his understanding there are only a few children in the state receiving such services and, likewise, there are only one or two agencies providing such services currently. He said this will eventually change.

Co-chair Cameron said he thought that community health centers should have been included on the panel and he apologized to **John Watts** for not having included them in this Molina arena today. He invited **Mr. Watts** to submit written testimony to members of the task force. He said this task force wants to help in any way they can with this process.

Peter Gray, Director of Operations, and **Mr. Sandy Dunbar**, Deputy Director, Molina Healthcare, were asked to provide updates on Molina and any responses to previous presentations. That PowerPoint presentation is available on LSO's website at:

www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_dunbar.pdf

Mr. Dunbar expressed his appreciation to the various associations for working with Molina to address challenges. He addressed provider services first, saying that the call center, upon implementation, received about 4,500 calls weekly; six months later that number reduced to 4,200 calls and in October, 2011, the call center got 2,800 calls weekly. He believes the system is becoming more stabilized through hard work by many people and outreach. Wait time at the call center has a goal of two minutes, which is the contract requirement, and in March there was a longer wait than that due to system problems, but that wait time now is normally less than thirty seconds. **Mr. Dunbar** said that the priority research team was developed since many providers were frustrated with major issues. In March, over 125 providers had escalated or priority issues and currently there are only 5 providers with issues. The only way to come off the list of providers dealt with by the priority research team is for the provider, Molina and the state to all agree that the issue has been resolved. Molina's contract requirement is to visit 140 providers throughout the state and he said that recently Molina has done over 180 one-on-one site visits. Co-pays started on November 1, 2011 and Molina had all their PRCs (provider regional consultants) do over 100 visits to providers in one week to make sure everyone was notified, they had information and knew exactly how this would affect their organization. With regard to quality assurance, **Mr. Dunbar** said that **Mr. Gray** would address that and processes in place to address that. When outcomes show that Molina is lacking in any area, Molina has a training program to identify issues. This training is provided to everyone associated with an issue, and everyone has to fully understand the training information through assessments, and 90% must be achieved in order to pass that training and be certified.

Mr. Gray first touched on the discussion regarding startup of the Molina program. In June, Medicaid claims started to be processed and it was a tremendous challenge. Molina committed the resources, the expertise and time to ensure that Molina moved forward to bring this project to a steady state. Some key challenges that needed to be overcome were in the area of provider enrollment, configuration which is tied to provider contracts, as well as rules for the claims processing, and also quality. Molina wanted to ensure as they moved forward that claims were not just processing claims or enrolling providers, but that the process was being done accurately. Specialized teams were formed in each area starting in the fourth quarter, 2010, to heavily focus on looking at the number of providers enrolled in a very short time prior to going live and what needed to be done to correct records with providers and ensure that billing could take place within the Medicaid system. Dedicated teams also looked closely at Molina's configuration and changes needed to be made, but also they needed to be made accurately. Molina, corporate, has over fifteen years experience auditing claims and they leveraged the Molina corporate claims auditing department to come in to ensure claims were being processed accurately for providers. They understood there would be reprocessing efforts and one reprocessing still being worked on with providers is COB, Medicare cross-over claims. Molina has a dedicated team, an approach, and they are delivering on that reprocessing to providers and associations who spoke earlier. Key to success of this project into a steady state has been collaboration with associations and individual providers. To ensure that Molina was enrolling and processing claims correctly, input was gathered and validated with larger providers which proved to be very successful. Weekly calls to a number of association members resulted in direct outreach, sending triage teams to provider sites to ensure that billing could be done within the new system properly since there were so many changes during the transition. The commitment was there and Molina did provide the resources this project needed to move forward. Currently, 95% of claims are

finalized within the first week, averaging about 140,000 claims receipts weekly, as opposed to 51% when the system first came up in June, 2010. Pending claims need to be worked manually by claims examiners, and these claims have gone down from 23% in June 2010 to 6% in October 2011. This is attributed to several factors: accurate provider setups, accurate configuration within Molina, as well as ensuring that the adjudication process as well as claims examiners are audited and properly trained. **Mr. Gray** pointed out two spikes in pending claims in May and June, 2011, and that occurred when Molina made a decision regarding COB claims. There were certain cross-over claims, recognizing the configuration was not correct, so Molina pended those claims so as to not process incorrectly, made the system changes, and then processed the claims. Right now, pending volumes are being worked in under thirty days, which is the contractual requirement.

Most important, **Mr. Gray** said, was the point that **Representative Rusche** raised earlier today regarding quality and auditing. Molina is conducting various types of end-to-end audits, examining the life cycle of that claim, conducting staff audits with each claims examiner to make sure steps are followed to reach a resolution and get that claim to a paid or denied status. Focused audits are also being done which are audits as Molina implements policy and changes within the Molina system such as upcoming House Bill 260 changes and House Bill 701. When new claims are processed, Molina wants to know sooner if there is any issue with Molina's configuration. Testing has been enhanced and quality assurance is part of that process. For current and future policy changes, **Mr. Gray** assured the task force that Molina is working very closely with DHW in reviewing changes and running test claims for provider type specialties to make sure they process correctly, prior to promoting those changes to production. There may be occasions where incidents occur, but systems are in place to respond quickly so as to not disrupt provider claims processing. Molina has also built quality assurance around enrollment, which is key; over 27,000 providers have enrolled in MMIS, a huge number to enroll and maintain.

Mr. Gray agreed to personally follow up with **Mr. Makizuru** about issues with the Children's System Redesign. **Mr. Gray** addressed interim payments, saying that Molina issued roughly \$117 million in interim payments when the system came up, and there were issues with claims processing and Molina started recouping from providers in October through December, 2010. To date, there is an outstanding balance of about \$4.8 to \$4.9 million, and Molina is working directly with providers. He made very clear that Molina and DHW made multiple attempts to outreach to providers and to work with them to set up payment plans before referral to collections. Molina's goal is to complete interim payment recoupment by July 2012.

Mr. Gray addressed system development; upcoming or ongoing projects currently with MMIS include HB 260 on which work is nearly complete, and CMS certification which he said was very positive since Molina had been working closely with DHW for several months in preparation. Great progress has been made having had rehearsals, and implementation takes place December 5-9, 2011, when Molina will participate in certification with DHW. Regarding HIPAA Transaction Compliance (5010), **Mr. Gray** said that Molina will be prepared as of January 1, 2012 to accept 5010 transactions, having worked directly with providers and communicating through Molina's portal and regional consultants to ensure that providers are testing with Molina. Testing for 5010 began in July 2011. Providers have the option of using Molina's portal to ensure claims do get processed. The system will be ICD-10 compliant in 2012 and Molina will work with DHW as changes are needed for 2013.

Mr. Gray noted key challenges brought up by IHA, ICHA, IMA, and DDA, and he said Molina is on the same page as these providers. Molina agrees with the challenges, and they are working with the

providers either individually or in groups to correct challenges, in order to move forward. The collaboration has been tremendous with the provider community, as well as with associations and members. **Mr. Gray** expressed his appreciation for the opportunity to update the task force on MMIS.

Representative Rusche commented that he really appreciated the quality assurance and quality improvement aspect of **Mr. Gray's** presentation and said he wanted to continue getting that information regularly from Molina, since this is key when going through transitions. **Mr. Gray** agreed completely and said that Molina has put tremendous effort into quality assurance and audits. **Mr. Gray** said that a weekly report is provided to the executive sponsor committee, which is the Medicaid Director and others, which reflects where Molina is at with audits.

Senator Lodge thanked **Mr. Gray** for the hard work done to resolve all the issues in this "perfect storm" since Molina purchased the program, as well as the correct and accurate methods being working toward for claims payments. This will help with Medicaid fraud and abuse, which is a huge problem. She asked how Molina has found the time to reach out to help groups such as DDA, one of 27,000 providers. **Mr. Gray** said that Molina can work individually with providers due to the efforts that the Molina team put forth, looking closely at the provider configuration, identifying problems, and making corrections. Looking holistically, the majority of providers are billing successfully; the key has been to get the provider regional consultants, get triage teams working with providers through web conferences, training in all regions monthly, to make sure providers are billing and enrolling successfully in MMIS. **Senator Lodge** expressed concern about the Children's System Redesign, since that legislation was passed in March 2010 and implementation was July 1, 2010. She asked if the providers were not given enough information to fill out the applications and if these same types of issues will result with each new development, and do changes need to be made. **Mr. Gray** replied that Molina started working with providers regarding the Children's System Redesign in July and the change did not go into effect until October, 2011 and it was **Mr. Gray's** understanding that Molina has some communication problems that need to still be addressed. Prior to any upgrade that impacts the provider community, Molina looks closely at communication and the roll-out to providers; there was a gap that needs to be revisited with providers who service these particular members about the enrollment process. If a provider is existing already in the system, there are three new provider specialties for this particular service, and Molina's portal allows a provider to do a provider maintenance request to add that specialty. If a provider chooses to do a paper application, that is available, but this can be done on the portal to add that specialty. **Mr. Gray** agreed again to follow up directly with providers having issues and will examine how this was rolled out and agreed to address any gaps through outreach to providers.

Senator Schmidt asked about the graph in **Mr. Gray's** presentation about recovery of interim payments and if there were plans for resolution of an end balance. **Mr. Gray** replied that one reason that recoupment payments have lessened is that providers who were issued interim payments may have low weekly claims billing. For example, interim payments were issued to certified family homes, so when recoupment is 25% (the standard claims recoupment) it's a much lower recoupment. Earlier in the graph are the larger recoupment amounts where providers were allowed to pay back in four monthly installments and some paid in full, but due to that earlier large claim volume, balances were paid off sooner. Resolution of an end balance is being discussed with Molina executives and DHW.

Co-chair Cameron expressed his appreciation at the efforts being put forth by Molina and he said that looking back, many mistakes were made and things that the Legislature could have done differently. Since **Co-chair Cameron** works on the state budget, and JFAC still cannot reconcile the FY 2011

numbers because of this system, he asked **Mr. Gray** to explain what the holdup is; what does he anticipate the resolution to be, since DHW is going to request a supplemental appropriation for the providers. If there is no confidence that numbers are accurate or can be reconciled, then this could be a real problem. **Mr. Gray** responded that he was not directly involved in terms of the state budget for Medicaid, but Molina has provided data as requested by DHW in anticipation of DHW's budget. Molina has worked with DHW regarding the CMS 64 report which is one of the key reports in terms of spending across provider-type specialties. In terms of data, it is available in the system, and Molina has worked very closely with the Bureau Chief of Finance and with LSO auditors to reconcile the interim payment. **Co-chair Cameron** said there is a significant concern about size of the interim payment given to nursing home facilities which now may be recouped which has an impact on the overall budget request from DHW to JFAC. Where is Molina at with this reconciliation and how soon can this be resolved? **Mr. Gray** answered that the majority of nursing facilities have already paid back their interim payment recoupment amounts; the comment from **Mr. Holloway** was in regard to share of cost and share of cost rates for 2009 and 2010 and Molina needs to work with DHW about how that would be recouped. **Co-chair Cameron** reiterated that Molina, providers, and the state are involved together in this very awkward issue, adding that the sooner this can be resolved to the benefit of everyone, the better, and he encouraged Molina to continue toward this effort.

The task force recessed at 12:35 for lunch and reconvened at 2:00 p.m.

The next presenter was **Mr. Mike Berlin**, Chair, Idaho Alzheimer's Planning Group (IAPG), and his PowerPoint presentation is available on LSO's website at:

www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_berlin.pdf

Mr. Berlin heads up this volunteer group, a grass roots organization (IAPG), and he is a clinical gerontologist by training who works with older people with Alzheimer's Disease (AD) or other mental health issues. His father-in-law has late-stage AD and his presentation was entitled "Alzheimer's Disease and Other Dementias - A Public Health Policy Issue for Idaho." The goal of IAPG is to have AD and other dementias identified as a public policy priority in Idaho, and IAPG is advocating for a statewide plan. **Mr. Berlin** identified members of the steering committee and was hopeful that a legislator would join this committee for guidance. Many states have state plans to address AD and other dementias and most have gone before state legislatures to ask for funding, but he assured the task force that he was not asking for any money. **Mr. Berlin** shared that if everyone in Idaho who has AD was brought together today, those people could fill Bronco Stadium, and this number is projected to double in Idaho in the next fourteen years. Getting older is the highest risk factor, beginning at retirement age. Care giving for these patients is a 24/7 job and 60% of caregivers have other jobs; the disease could take up to twenty years to run its full course and can cost families a fortune. Keeping patients safely at home with loved ones can greatly reduce costs. Death rates have declined for most major diseases, but deaths due to Alzheimer's Disease have risen 66% during the same period. This group is embarking on an awareness campaign, collecting data and getting community support for development of a statewide plan. The group has a legislative agenda to recruit a legislator for IAPG, to consider requesting a concurrent resolution in support of grant applications and to work with state agencies during plan implementation.

Dr. Troy Rohn, Boise State University, Department of Biological Sciences, informed the task force that dementia represents symptoms of AD which is an irreversible, progressive brain disease that slowly destroys memory and thinking skills. Advancing age is the greatest risk factor. **Dr. Rohn** explained how AD causes functional and structural changes in the brain which cause symptoms and drastic consequences with communication. Current research goals include early detection and prevention; to

provide disease modifying treatments; preventative therapy that delays onset of AD symptoms; delaying AD to allow affected individuals to live their life at home; and to provide education to communities about healthy brain strategies including mental and physical exercise.

Dr. Sarah Toevs, Boise State University, Center for the Study of Aging, spoke about opportunities to improve the spectrum of prevention, diagnosis, treatment and caregiver support services for AD and other dementias. The key to keeping AD patients in their homes is Medicaid home and community-based services. Opportunities in Idaho for AD patients include the Idaho Home Choice Project; 2011 Medicaid Managed Care Plan; and the Idaho Commission on Aging. Moving forward with these initiatives is key to assuring that there is improved coordination of services, elimination of duplicated services, and providing Idahoans with care and support. Lots of AD research is going on to slow the onset of the disease which is a lifetime initiative. Awareness including such things as concussions playing football in elementary school, nutritional quality as an infant, and public education lead to better brain health and implementation of early preventive strategies. A plan needs to be in place for this looming epidemic, in IAPG's opinion to take proactive steps to address this issue before it completely overwhelms the system. In Idaho, the number of individuals over age 85 was 18,057 in 2000 and that population will be 47,000 by 2030, showing a rapidly growing, aging population and AD in Idaho is projected to double by 2025 to affect 52,000 to 64,000 people. Informal caregivers in Idaho currently number 73,000 providing over \$900 million of unpaid care. Steps must be taken to provide support to caregivers so they can continue caring for these patients. Medicaid is the primary payer of long-term care expenditures and the estimated cost of care in a semi-private skilled nursing facility averages \$75,000/year, in addition to lost wages for caregivers. These challenges need to be addressed and IAPG is working toward development of a statewide plan that will integrate management of AD and other dementias into initiatives. To bend the cost curve, caregivers must be supported and move forward with early prevention to delay AD onset.

Dr. Toevs concluded by saying that IAPG will continue with goals, a legislative champion would complete the steering committee, and a concurrent resolution in support of IAPG would give credibility to build a plan.

Director Bill Deal, Department of Insurance (DOI), presented next and his PowerPoint presentation is available on LSO's website at:

www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_deal.pdf

Director Deal said that DOI considers itself to be a partner in many issues regarding health care. He applauded the efforts of IAPG to develop a plan, since AD had personally affected a family member, which involved the entire family. **Director Deal** updated the task force on Idaho health insurance exchanges by saying that DHW applied for a Level 1 Establishment Grant Application and on October 31, 2011 there was opportunity for a budget negotiation with Health and Human Services, resulting in revision of that grant. The budget was modified from \$30 million down to \$20 million. Background research and studying has been completed on what other states are doing about participation and fifteen states had implementation legislation passed by their legislatures. This is consistent with what is going on across the country. DOI is looking at other states in detail, a favorite being Oregon, since Oregon is close and the people there are familiar to DOI in Idaho. Oregon is moving along quite rapidly with an exchange. A full-time director has been appointed, Rocky King, who is a very dynamic person. DOI is keeping updated daily with advancement of other states as they move forward with exchange plans. DOI is researching information on Idaho's demographics, what business owners want, etc. Surveys have been made to define coverages, how to buy inside or outside the exchange. A lot deals with the uninsured and how they would move into an exchange, particularly if web-based, and how what website should be

designed. A big question is will employees still want to stay under a small group policy with employers which is one issue that surveys will cover. DOI hopes to have this information available by session. DOI is going to initiate new research and ask business associations to help with an online survey dealing with key issues that business owners have about goals and philosophies and what kind of benefits a business owner wants, how to ensure employees will stay in a program, what the goal is and benefits. This survey will be very helpful. Stakeholder involvement is the big issue that DOI continually deals with; DOI has met with Idaho Tribes; producer meetings have been held as well as legislative governance working groups. December 1, 2011, DOI will go statewide to conduct nine meetings throughout the state in all regions to get information out and to gather public comments, both of which are key as the state moves forward. DOI has completed program integration, meaning establishing a partnership with key Medicaid stakeholders for integration with the exchange. DOI will continue identifying Medicaid readiness needs for integration with the exchange. Information technology is the name of the game as the state moves forward with a vision of an exchange. Conceptual IT architecture for an exchange is how to hook up to the hub, how insurance companies are involved and this requires a high level of expertise. There are components that need to be included in the exchange and some information is very necessary for quotes for items needed in the exchange. It is important that in building an exchange there are many parts of the exchange that include “buy-off-the-shelf” type of software. At the NAIC Conference (National Association of Insurance Commissioners) several weeks prior to this meeting, there was a resolution put forth and Idaho was a co-sponsor urging the U.S. Health and Human Services to take action to ensure the continued consumer access to professional health insurance producers. That is a resolution to be voted on November 26, 2011 by the commissioners, and a number of sponsors think this is a very important part as the exchange goes forward.

Legislative governance was the next item for discussion, and **Tom Donovan**, Deputy Director, DOI, handed out a piece of draft legislation which is available on LSO’s website at: www.legislature.idaho.gov/sessioninfo/2011/interim/healthcare1117_deal2.pdf

Tom Donovan has been a coordinator of an exchange working group having to do with implementation legislation for an exchange. This draft, he said, had been an ongoing work in progress, and drafts have been circulated. He went over the purpose, intent and desires for an open market, a market-driven exchange in Idaho, and the requirement that individuals participate as an option. It will be designed as a choice for Idahoans. **Senator Corder** said he appreciated a market-driven exchange, but he was trying to understand if voluntary participation of carriers would meet the expectation of the state’s obligation to conduct an exchange, with no products offered there and, if that could occur, on what basis would a carrier not want to be in an exchange. **Co-chair Cameron** interjected that this is one item for discussion at this point and initially there was a requirement that if health insurance was sold in Idaho, there would be a requirement to participate in the exchange. Then that was removed in an effort to make it clear that Idaho wanted to make it as voluntary as possible so that no consumer would be required to purchase. That does raise issues, another of which would be carriers cherry-picking inside or outside the exchange and, if carriers participated in the exchange, whether that carrier would be required to have all products inside the exchange. **Co-chair Cameron** said there is a separate working group coming to a resolution as to the best possible solution and he said he personally favored by virtue of being a carrier in the state, to market through the exchange as well as outside the exchange. **Mr. Donovan** added that this definitely is an issue and a topic of discussion.

Representative McGeachin had a question on an earlier version of this draft legislation, language not in this draft, which seemed significant to her, that being selection and purchase of affordable and quality products, and she wondered why this language was stricken. **Mr. Donovan** answered they absolutely are

still interested in affordable and quality products, but the terms were deleted because they didn't want the exchange to be potentially viewed as guaranteeing those attributes, rather the idea is that the exchange will help facilitate the market, and the market should drive the results. The exchange will be just another means for Idahoans to purchase insurance and facilitate that process. **Co-chair Cameron** added that one concern seen as we compare Idaho to other exchanges, in some states the exchange will actually develop and regulate products, and will determine what a qualified health plan is. He didn't think Idaho's exchange should do that, but thinks this should fall within DOI. The exchange would be simply a conduit, a website, a location to assist individuals and/or businesses to obtain coverage. The exchange won't develop the coverage, judge it or underwrite it. **Co-chair Cameron** said that was an issue, and he didn't want the inference that somehow the board or the state would end up doing that; that should be a private sector decision.

Mr. Donovan continued going through the draft legislation covering definitions and establishment of the exchange and board. **Senator Corder** asked about 41-6104 (9) "The board and the exchange shall not be subject to the purchasing statutes and rules of the state of Idaho." Is that customary language for other boards, or is this deemed to be necessary because of what is actually being supervised? **Mr. Donovan** said that language was designed to apply to purchasing both statutes and purchasing rules and that issue will probably be addressed in relation to the other comment about the exchange potentially closely tying in to DOI, and that is an issue to work through with this kind of draft.

Mr. Donovan went over "exchange plan of operation" in the draft, and **Senator Corder** asked about why health benefit plans would include stand-alone dental policies and if that meant that the exchange itself might not offer a group of stand-alone dental policies or are all health plans going to be required to have that as a component. **Mr. Donovan** answered that it is just permitting the sale of either. Dental benefits certainly can be included within a health benefit plan, but it's also permissible for a stand-alone dental plan to be sold as a separate plan, and **Co-chair Cameron** said that it is not a requirement that they do so.

Representative McGeachin asked about line 23, page 5, "The exchange plan of operation may be amended at any time by the board consistent with the requirements, purpose and intent of this chapter." She said this seemed very broad, what authority the board may have in relation to policy where things are spelled out and is clear. **Mr. Donovan** answered that he didn't think the board would be able to increase its own authority by modifying the plan of operation and amending it; he thought it would be limited to whatever is permissible within the scope of plan of operation initially. He directed her attention to Page 6, line 20 under "Powers and Authority" to adopt a plan of operation and following that it provides for rulemaking authority. That may be an issue that could be dovetailed with the authority of DOI. To the extent the plan of operation provided something that really needed to be in a rule, that would give the board authority to give the public opportunity to comment and give input properly. **Co-chair Cameron** said there had been discussion about who would approve the plan of operation and how that could be amended. The attempt is to model this after the high risk pool and how that pool operates and amends, as necessary, but those amendments are more in the nature of how the exchange would operate, not necessarily public policy-type decision making. There was discussion about whether they should be required to go through the expense of issuing rules or whether that would fall under DOI and DOI would promulgate rules if there was a public policy implication. He thinks that the exchange board will be trying to make the exchange operable online similar to a travelocity-type sight, making it consumer friendly. **Senator Schmidt** commented that it would be helpful to him to include "plan of operation" in the definitions section, and **Co-chair Cameron** agreed.

Mr. Donovan continued with the draft, going over “powers and authority, report, severability and effective date” sections and **Co-chair Cameron** said that there are still about six items “at issue” in this draft. He said he hoped that the final draft of this legislation could be available for the December 14, 2011 meeting. This draft is a work in progress, but the draft is getting closer toward what an Idaho insurance exchange could look like.

Senator Schmidt asked about page 6 of the draft, 41-6106 (d) on line 35, under “powers and authority” - “Receive and share information that is confidential and exempt from public disclosure from and with persons and governmental agencies.” Would that be a requirement that this exchange be HIPAA compliant in terms of its exchange of information? **Mr. Donovan** said he would expect that to be the case. One thing talked about is that federal provision provides for tax credits to be made available under the exchange, and to the extent that personal and health information is shared, which it may be, then it would have to HIPAA compliant, he assumed.

Co-chair Cameron said one issue discussed was that the draft needed stronger language with regard to defining contribution or shop programs, and this will be discussed further. This could be a real benefit to employers in districts should the exchange be able to have a defined contribution type approach, which would be a blessing in an exchange to try to help employers provide health insurance to their employees.

Co-chair Cameron said he had heard gross exaggerations about what an Idaho exchange might cost; he pointed out that much of the initial set-up cost would be borne by the state or by the federal government, depending on whether Idaho chooses a state or federal exchange. These costs are unavoidable, unless the health care act is overturned completely. He asked **Director Deal** if there is a conceptual cost of what DOI anticipates the exchange to cost annually. **Director Deal** said DOI does not yet know what that ongoing annual cost will be, which is key to this whole operation. **Co-chair Cameron** reminded the task force that there is a requirement under the federal legislation that the exchange be self-sustaining. If Idaho is able to develop this exchange as a truly private sector exchange, with the state being involved only in the development, it would be funded essentially by those participating. Participants would include carriers and/or users, as outlined in the draft legislation, to be self-sustaining. This would not affect the general taxpayer, which is a provision of ACA (Affordable Care Act).

Senator Schmidt asked about provisions explicitly prohibiting required participation; he had a vague recollection of a presentation months ago when Director Armstrong (DHW) talked about how Medicaid participation would be screened through the same entity used to determine qualifications for insurance. He wondered if that would be separate from the exchange or participating in the exchange when being screened. **Director Deal** replied that there are two sides of the exchange: (1) the exchange itself which is talked about in this draft legislation that will have insurance companies provide coverage and the other side of the exchange is (2) Medicaid. **Director Deal** looks at it as a one-way street in the beginning since all applications for coverage under the ACA will begin with the qualifiers. He explained that an application would be submitted, that goes to the qualifier, a determination would be made as to where that application goes. At this point, one of the main qualifiers is percent of federal poverty level; one percentage would go to Medicaid and if exceeding that level, the application would go to the exchange. **Senator Schmidt** said that his understanding was that under ACA there will be support for people at different levels of the federal poverty level, so an applicant may move back and forth. He expressed concern about the requirement prohibiting people from filing for this program, since there are times that he thinks people should apply for Medicaid. **Co-chair Cameron** said this may be a public policy decision but warned that many other legislators might have a difficult time to mandate enrollment in

Medicaid and/or a plan. The philosophy generally in Idaho has been that this portal or exchange should be a mechanism to assist, but if someone chooses to not participate and to go in a different direction, then that should be allowed. One of the difficulties is whether the exchange would be federally qualified and there is discussion with this draft, even with modifications, whether it would be completely federally qualified. **Co-chair Cameron**'s attitude is that this legislation should be drafted for an exchange to best suit Idahoans, then attempt to get this legislation passed, and if it is determined that the exchange would not qualify, then issues could be addressed as they arise, since everything is unstable currently.

Senator Corder said it would appear that a successful exchange would provide the opportunity for reinsurance for counties, a significant offset that may then also negate that requirement for mandatory coverage if a reinsurance mechanism is available. He said that solves that other problem, and he asked if that was correct. **Co-chair Cameron** replied that he thinks that an appropriate exchange would assist multiple entities, including counties, certainly employers and others in purchasing affordable care. The word reinsurance was mentioned, which **Co-chair Cameron** said was still an item of discussion and has not been addressed initially in this draft legislation, but most likely would be an issue in the plan of operation. He said that acts do require some level of reinsurance to make sure that entities are not harmed by either participating or not participating in an exchange. Some of that reinsurance mechanism is there to level the playing field because of PPACA and requirements of plans at a certain point. These will be steps down the road, depending upon elections and court decisions which will determine whether Idaho has to have a reinsurance mechanism and what that would entail, coupled with where does the high risk pool current mechanism fit and do they work together. An exchange should help counties, especially smaller counties, and any employer, any individual wanting to purchase coverage should be helped from an exchange. **Co-chair Cameron** applauded **Director Deal** and DOI for trying to make this draft legislation on the exchange an open process, which has not been easy. He said he could not recall any issue that has caused more angst, more apprehension and maybe more misunderstanding as to what an Idaho exchange will or will not be. There is much fear on the part of consumers, employers, carriers, and providers as to what this exchange will be, so the more parameters that are outlined about an exchange, then some fears can be alleviated.

Co-chair Cameron invited **Dr. Louis Schlickman** from the audience to testify. **Dr. Schlickman** said he was a primary care physician specializing in internal medicine in Meridian; he said he was speaking on behalf of the general public. He wants to make sure an exchange will work well for Idaho and one concern he had was about the makeup of the board. He wants a balanced number of members to best reflect the community. He expressed concern about the way the board would be set up in the draft legislation, which he thought was weighted heavily toward insurance carriers and producers or insurance brokers versus other members representing small businesses including hospitals and physicians. The idea of an advisory committee removing a physician board member or nominating a board member, he thought was a nice idea and wondered if that would also be appropriate even for the insurance carriers and producers. Regarding part-time employers, is there an idea of what their access would be through the exchange and he asked how that is being evaluated.

Co-chair Cameron answered that with regard to the board makeup, most issues, in his opinion, will be technical in nature, involving IT people and IT discussions and how to make the portal work, to make sure that comparison and plans offered have adequate information efficiently available. The role of a provider on the board would not be in designing, judging plans or trying to influence how a plan is designed, unlike other states. Idaho's draft is trying to make sure that is not the role of the exchange board and that any requirements the exchange should have would go through DOI under either state or

federal law requirements. There may be at times a need for technical assistance from the provider community, and because of that, rather than having one or two board members, it might be better to have an advisory committee. It was decided that this would not be an optional committee, but rather a requirement to create an advisory committee made up of providers. That committee could provide advice and consent to the board if issues of a technical nature arose with regard to providers. **Co-chair Cameron** didn't think there would be issues of concern occurring. Letters have been received from numerous provider groups and that list is endless. Certain language was inserted in the draft legislation that the board cannot have carriers and insurance agents or producers making up the majority of the board. Consumers and the Legislature would make up the majority of the board and carriers and producers would be making sure the site is effective, usable and information has the ability to transfer between the exchange site to the individual company's ability to issue policies. **Co-chair Cameron** said that with regard to availability of the exchange for part-time employees, the federal act calls for small employers to participate if they provide coverage to all full-time employees. The language in the draft was softened to make sure that if an employer wanted to offer to part-time employees, they could come through the exchange. The restrictive language in the federal act was removed and opened it more broadly so that any employer who wants to help provide coverage for employees ought to be able to come through the exchange, whether full or part-time. **Dr. Schlickman** asked again about part-time employees and **Co-chair Cameron** clarified that the exchange draft legislation would not create any penalty and part-time employees absolutely would have access either through their employer or on their own. Under the federal act there are some penalty provisions, but penalty provisions would nothing having to do with an Idaho exchange. **Dr. Schlickman** asked about minimum benefits and level of care set at the federal level. **Co-chair Cameron** answered that if the Affordable Care Act stands, requirements for qualified plans would be set at federal or state level and that still would be administered, monitored and regulated through DOI. That influence would still occur there, but the exchange board would have that ability, which is different than what other states are doing. **Dr. Schlickman** asked if the state had the opportunity to improve the baseline of meeting minimum standards, and **Co-chair Cameron** answered that would require legislation and going through DOI. **Dr. Schlickman** suggested consideration of an exchange option unique to Idaho in nature, such as what a public-utility model might offer. He thinks that would give Idaho a better opportunity to oversee plans and would make them more affordable for the state; he didn't think going through an exchange would be a big money saver for Idaho. **Co-chair Cameron** agreed to have a conversation about this with **Dr. Schlickman**.

Gretchen Eickmeyer, an audience member, was invited to testify and she said she was Vice President of University Advancement, Health Sciences, Pacific NW University, Yakima, WA. She said the university has 37 students from Idaho training to become primary care physicians in Washington state. These are students who attended colleges in Idaho. They are in Yakima for two years of medical school and then coming back to Idaho to do third and fourth year training and then will hopefully enter residency slots as they hopefully open up. She thanked the task force for supporting **Dr. Ted Epperly** and working with him to expand residency slots. Idaho is getting a pipeline built, she said, and there is now one student accepted to join the residency program and fourteen students who are training in Idaho facilities. The remaining students are in their first and second year. She wanted the task force to know there are Idaho students practicing to become primary care physicians. There are 300 students from the Pacific Northwest and the first class will graduate this May and are passing national board exams with flying colors. Seventy percent of students this first year chose primary care residency programs which include family medicine, ob/gyn, general surgery, internal medicine, and psychiatry. Eight new residency programs have just been approved. Hopefully, these students will remain in the Pacific

Northwest, working wonderfully with WWAMI residency programs to dual credit some programs. **Dr. Epperly** has been wonderful and she encouraged the task force to support his needs as a collaborator. She encouraged support of graduate medical education because students stay where they do residencies. She thanked the task force for this opportunity to speak.

Co-Chair Cameron invited draft legislation to be presented to the Co-chairs or to **Ryan Bush** in LSO for consideration in advance of the December 14, 2011 meeting. He also invited testimony on any draft legislation at this next meeting.

The meeting was adjourned at 4:00 p.m.